WHICH WORLD DO YOU LIVE IN?

Which World Do You Live In?

The mental health world in which clinicians practice is increasingly more difficult to focus on one's own theoretical base and principles. Each new addition of DSM adds more and more "disorders" that reside within the individual. The insurance industry demands the individual disorder diagnosis for reimbursement. "Event tickets" to be completed by clinicians have options for family, couple, non-patient sessions, but the practice or agency will receive no reimbursement. Because of financial pressures, the M. H. agency demands that clinicians only provide services that are "billable." Medicaid, because of escalating expenses, is redefining and reducing which services are "billable." The majority of private H.M.O.'s limit the number of sessions they will cover. Justifications are required for additional sessions and are reviewed by insurance case managers who are charged with reducing costs.

Increasing "confidentiality" laws prohibit clinicians from having contact or communication with family members and the "identified patient," unless permission is granted in advance. Many horror stories occur, such as family members being unable to locate a psychiatric relative, not knowing whether the person is in a hospital or on the streets. Agency/hospital staff feeling caught between the patient and family, and unable to think being connected to both sides of the triangle, perpetuate the escalating emotional process by refusing to communicate with family members since the patient hasn't given "permission." The emotional war within the family continues.

The direction of psychiatric science (not to e equated with neuroscience) moves increasingly towards more and newer drugs, which the pharmacy industry is more than happy to support with "research" dollars. It is rare to read any research/ medication evolution report that is authored by someone who hasn't received funding from a major pharmaceutical company with major interests in the financial success of the "new and better" medicine. This, or course, applies to the entire industry, not just with psychiatric medication initiatives. There is also an increasing acceptance

of physician using “off label” meds to treat psychiatric problems. The current “love affair” with anticonvulsants in the treatment of “mood disorders” is one example. Polypharmacy seems to be the practice norm, with the assumption that more is better. Symptom relief is the criteria rather than looking at possible long-term consequences. The percentage of T.V. commercial time during prime viewing hours and ads in News Weekly Magazines seems to be increasing. Side effects are rapidly mentioned in the last seconds, with the caveat “ask your doctor.”

With all these pressures for one’s well-being, shift to the environment’s definition of solutions to problems and the clinician becomes more and more defined by this eroding process. The realities of the above forces and trends cannot be ignored, but where can one start in defining one’s practice principles while being connected to this hostile environment? If a clinician is so bold as to ignore these realities, unemployment is a predictable outcome.

Dr. Bowen was well aware of these realities and found a way to operate in the environment. Thirty years later the situation has only escalated. His letter of March 29, 1971 reflects his principles in reference to family emotional processes while dealing with requirements from the environment. Again, this is a “both/and,” not a compromised position.

March 29, 1971

Dear Mr. and Mrs.

Enclosed is a bill and the completed insurance form.

A bit of explanation is in order about billing for family psychotherapy. A main advantage of a family orientation is thinking of the problem as a total family problem and "treating" it as if it is a family problem, in contrast to conventional psychiatry which diagnoses and treats the illness in the patient. The more successful each family member in discovering and modifying the part that self contributes, the more quickly the problem resolves. The more successful the family and therapist in avoiding conventional concepts such as "patient", "illness", the making of diagnoses, and the concept "treatment", the faster the resolution. Routine bills are always made to "Mr and Mrs" as equally responsible for any problem in the family.

Family psychiatry is too new and there are too few family therapists for insurance companies to have developed rules and procedures for it. Any attempt to explain "family" to an insurance company results in endless snarls, red tape, and confusion. So, for insurance purposes only, it is necessary to follow the conventional system. In my practice, I permit either spouse to be listed as "patient", bills are made to that spouse along, and insurance forms carry the most minimal diagnosis acceptable. This also permits one spouse to be the "patient" for one block of time, and the other for another block of time. All of this is to explain to you that Mr. is listed as the patient on the bill and the insurance form, for insurance purposes only, and not because I consider him a "patient". Both of you will be ahead of the game when you finally are out of the mold of thinking and acting as if he is the "sick" "patient". That's a good assignment for you.

It is good to hear that things have been going better for you. From the best estimate I can make on July, it looks like the week of July 12 might be one of the more favorable weeks for me.

Sincerely,

Murray Bowen, M.D.